ORAL ARGUMENT – 09/09/04
03-0497
ROMERO V. KPH CONSOLIDATION

HOGAN: This is an exceptional case, and it is exceptional for two reasons. First, contrary to the hospital's position in this case, the legislature has not immunized hospitals from credentialing claims. Malice is a high hurdle, but the Romero's cleared it and they cleared it with clear and convincing evidence. The second issue in this case, the charge issue, goes away if the court agrees with us that the Romero's have established with legally sufficient evidence their malicious credentialing claim.

But the CA's opinion in this case in which it reverses a separately submitted and unchallenged separate theory of liability because it reversed on no evidence grounds a completely different, separately submitted theory is unprecedented. And it greatly complicates charge practice in Texas and it upsets the very careful balance that this court has to this point struck between error preservation in the trial courts and review of jury verdicts at the appellate court level.

Because malice is dispositive of this case and because we proved it, that's where I would like to start this morning.

Malice, I think we're all familiar with the standard that was submitted in this jury charge. The standard definition required basically proof of three elements: an objective risk element; a subjective awareness element; and a conscious indifference element. On the objective risk side, Dr. Baker who was the surgeon who the hospital gave credentials to and allowed to perform this surgery on Ms. Romero, Dr. Baker is and was an admitted drug addict.

O'NEILL: Is objective risk even an issue here?

HOGAN: I would think not. I hope that the court would agree with us on that, and particularly given the direct evidence that's in the record, we don't think it should be. The man is a drug addict. His wife testified so. Two of his office managers testified so. We've got his drug records in evidence. I can't imagine that there's anything less than legally sufficient evidence under any standard of his drug addiction.

The second prong is subjective awareness. And again, this is not a case that is in any way built up on speculation, piling up of inferences. This is a one inference case on subjective awareness. The one inference that we want, that we asked the jury to make, is an inference that the hospital did what the hospital director of quality assurance testified that the hospital was required to do, and would do. And by the same token that the hospital did what the hospital's credentialing expert, that the hospital brought to trial, that the hospital did what that expert said that the hospital was required to do, and would do, and that the expert assumed the hospital

would do. That's the only inference we need, that the hospital did what its employee and its expert said the hospital would do.

HECHT: Didn't the CA agree with you on that?

HOGAN: Absolutely. The only thing the CA disagreed with us on was conscious indifference. The hospital has taken the position in its brief before this court, it doesn't really support the CA's opinion on conscious indifference. It backs up and returns and wanted to argue objective and subjective prongs again. Which is the position that they took in the CA. There was really - the hospital never made at the CA's level the argument that the CA accepted and wrote on, which is that given objective risk and subjective awareness that, nonetheless, there was no evidence of conscious indifference. So it was somewhat surprising to us to see that as a result, but we think that that was a mistake that the court made.

HECHT: But coming to conscious indifference. Looking at page 23 of your brief. And you say Romeros proved that the hospital allowed a known drug addict to perform an elective surgery, did not suspend him, did not restrict his credentials. And then you say they also offered evidence about a variety of actions the hospital could have taken to mitigate this risk. And they proved that the hospital chose not to take such actions. And then you say considered alone this is at least some evidence of the hospital's conscious indifference. And what I'm wondering is why don't you need some evidence that the hospital should have done one of the things that you say they could have done?

HOGAN: We do have evidence that the hospital should have - we have evidence that the hospital should have suspended Baker. We have that evidence that they should have terminated his credentials. We have that evidence from our expert, Dr. Eichhorn...

HECHT: Right. The CA cites that. Eichhorn's testimony: the hospital should have suspended Baker before the surgery. It was based not only on the drug abuse, but also on the Chavez surgery.

HOGAN: And that's simply incorrect. That's not the way the record reads in any sense. Dr. Eichhorn in his testimony, and this testimony is in Vol 6 of the record. First he was asked the question on page 72 of vol. 6: Are there steps that the committees can take in order to determine a) whether suspension should take place? or b) whether some kind of testing should take place? Answer: Yes. Definitely.

None of this is predicated on - not objective to. And what should have been done in this case? And he talks about there are several parts to it, that classic components is called a confrontation. He should have been given an immediate drug test, random, unannounced, blood and urine test, and the other part is the investigation and that includes investigating other institutions. And that the drug testing should be supervised. Absolutely.

On page 73 of the record, Dr. Eichhorn is asked,

Q: Was Dr. Baker still on the staff at the time of the Romero surgery? A: A: Yes. Definitely. Obviously. He operated that day.

Q: He had been suspended from Cleveland a couple of months before?
A: Yes, he had.

Q: Is that what Kingwood should have done in this case?
A: Yes, definitely.

There is no doubt that our expert said that the man should have been suspended. There is other evidence from Dr. Eichhorn. He talks about what happened with other people who he was involved with, other doctors who were impaired, how they were confronted, how they were suspended, how they were terminated, how they were sent to counseling and then they were slowly brought back in.

HECHT: With respect to the passage that I just from your brief, you need evidence that the hospital should have done something that they didn't do?

HOGAN: I think that you can have an inference. I think that this jury is allowed to determine from the evidence that it hears, that you have a drug addicted surgeon and that that poses an extreme risk, and that the hospital has knowledge of it. I think the jury can conclude that by him being there that day and operating. They don't have to have someone tell them directly that's a bad thing to do. I think the jury can conclude from what it has heard about the way credentialing works, that a doctor has to be credentialed, he can't be there without the hospital's permission, and allowing him to perform this particular surgery.

HECHT: The CA says that Dr. Eichhorn testified that the hospital committee should take various steps: confront; do drug testing; conduct an investigation, and then there might be monitoring and education and restrictions and counseling and determination. And in the briefs you yourselves argued that maybe another doctor should have been present. But how can the jury know whether the doctor should have been in the operating room that day without some evidence of that. It seems to me you need that. You say you have it, but it just seems to me you need it.

HOGAN: I think we have it. You want to say we need it. But I don't think that you need - I think this is a classic example that there are - first of all I want to back up. The CA is also slightly wrong when it talks about what that testimony is. And the court can read that in the record, too. Because there is general testimony in this record about not knowing anything about what the credentialing committee knew in this particular case. Let me just ask you Dr. Eichhorn, and the hospital's expert Dr. Bender, and most of this is coming from the hospital. And the question, from a general perspective what kinds of actions can hospital credentialing committees take? And not even restricted to drug abuse or drug addicted doctors. And that's the way you get this whole litany

of different actions that a committee can take. But it's always divorce from any sort of a factional scenario. No one offered any testimony that you could have a drug addicted doctor and that you could know that you were dealing with a drug addicted doctor and you could allow that guy to be in surgery even with an assistant, even with monitoring, even with drug testing. There is none of that kind of testimony in this record dealing with the facts of a known drug abuser, you can do anything other than terminate his privileges.

HECHT: Then I'm puzzled. You say on page 9 of the brief, you fault the hospital for not requiring another surgeon to be present to monitor and take over when necessary.

HOGAN: We go on. I'm dealing with what the CA says and what the CA even ignores about the additional kinds of facts that we have. Because if you want to credit this testimony that when you have someone who is accused of drug abuse that there are multiple steps or things that you can consider. In that circumstance even, we go on and say, Look if you want to look at that, if you want to credit that testimony, then look at what we've got. We've got a guy who was not suspended, he was not terminated, his privileges were not restricted from keeping him from performing this surgery. And in additional to that, there is no suggestion that - we know there was no other surgeon in the operating room with him, and we know that the anesthesiologist weren't warned or told anything about this surgery, and we know that the Romero's weren't warned in any way by the hospital despite their subjective awareness.

Frankly we have an inference that they weren't drug testing him. Because we know he was a drug addict. We've got plenty of that evidence. They couldn't have been drug testing him. They certainly couldn't have been drug testing him properly and not know that they were putting a drug addict in there. But I think all of that is just additional evidence. Do I think we have to have had it in order to have legally sufficient proof? No. But it is here. And it's something else for the court to be able to look at.

I think that from a conscious indifference standpoint, the CA suggested that we need to disprove any possible action that the hospital might have taken to deal with a drug addicted doctor. And that's completely contrary to the way we handle gross negligence, or malice in past cases. We have come forward with proof of a drug addict who was allowed to perform surgery and couldn't perform surgery unless the hospital with its subjective awareness allowed him to do so.

HECHT: Let me take you to the second issue. If the negligent credentialing claim should not have been submitted, then why isn't the way the case was submitted error? Assuming that it was preserved. I'm trying to get past the waiver arguments. But assuming that a good objection was made, isn't it error to submit an invalid claim with a valid claim?

HOGAN: I don't think we did submit an invalid claim with a valid claim here. What the court has said in Casteel and in Harris County is, is that you are going to submit - Casteel especially where we started from. We accomplished that, and we did it because of Casteel. There

is a separate question that finds liability and causation are negligent and the jury is specifically instructed, Do not consider the conduct of the hospital in credentialing Dr. Baker in answering this question. Instead consider only the conduct of the hospital and its nursing staff and its blood bank personnel. So there was a complete separation of those theories.

WAINWRIGHT: Assume that the CA was correct and you lose on the credentialing claim, then you have a negligent cause of action and a malice cause of action at the TC. With one apportionment question for both separate theories of liability and one damages question. For both, two separate, different theories of liability. If one of those two is found to be invalid, as was just asked, how can we tell if the jury based their apportionment decision and their damages decision on the proper theory, the one that was upheld if one is upheld?

HOGAN: First of all damages. There is no suggestion that the damages are different in this case because of the credentialing errors as opposed to the negligence errors. There is no evidence of any sort of separate damages that are caused between those two theories. Nobody ever said there was a divisible injury. This was submitted as an indivisible injury case. I think the damages would just have to go away.

Let's talk about apportionment because it's at least slightly different. I understand that the argument that's made is that the Romero's argued that some portion of the responsibility ought to be placed on the hospital for its negligence and for its malicious credentialing. I don't think you can decide this case accept from a policy standpoint: do we want individual enforcement questions and then how are we going to look at harm. Or, do we want multiple apportionment questions. We are going to have to submit apportionment questions in these cases and we need to figure out how we are going to do it and how we are going to keep cases from being reversed. And I think the answer to that, for all the policy reasons that we set forth in our brief, are that individual apportionment questions are better and that the burden ought to be on the complaining party to show harm, to show that the jury's 40% apportionment in this case to the hospital depends on the credentialing claim. And I don't think you can actually get there. If you look at what the CA said, they said that we argued that the jury ought to put responsibility on the hospital because of its malicious credentialing. And that's true. We told the jury to put 80% responsibility on the hospital for its malicious credentialing. The jury put 40% responsibility on the hospital. They put 40% responsibility on the doctor.

If you look at the bulk of the evidence in this case, you are going to find a case that has a lot about credentialing, but it opens up and has a lot about the hospital's negligence in terms of its blood bank.

WAINWRIGHT: You kind of dismissed the question with regard to the damages issue. You don't think a jury is going to view damages differently if you prove negligence verses proving malice when they decide how much to assess in damages?

HOGAN: No.

WAINWRIGHT: You think a jury is going to view the damages question that malice is proved the same as if only negligence is proven?

HOGAN: Yes. I think when you sit at the court and you review the jury's evidence on damages, you never consider whether the liability theory is malice, or the liability theory is negligence, or the liability theory is products, a strictly liability theory. I don't think that affects the damages question at all. The damages focuses on the injury to the people. And that's what we have to have evidence to support when you submit it to the jury and when we bring it back to this court. That's what you look at.

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RESPONDENT

O'NEILL: Are you advocating getting _____ or saying there is no such thing as a negligent credentialing claim in Texas?

MCMAINS: Actually this court did that in Agbor in terms of saying there is no such thing as a negligent credentialing claim.

O'NEILL: So you're saying there is no such thing as malicious credentialing claim?

MCMAINS: No. I'm not saying that there isn't a potential or possibility somewhere but...

O'NEILL: Tell me what that would look like if not this case?

MCMAINS: The legislature has rejected any attempts to modifications of Agbor that the amicus suggested were attempted in 2001. There is clear legislative intent of a malice requirement. Malice requires by definition conduct that is consciously indifferent. There is no evidence of any conduct in this case.

O'NEILL: By my question is, with the privilege you would never be able to get evidence of conduct. So in effect you are abolishing the malicious credentialing claim.

MCMAINS: First of all, the reason that the heightened element to malice of ordinary negligence was found justifiable in Agbor.

O'NEILL: I'm just saying I don't see how you could ever meet it.

MCMAINS: J. Phillips made that observation in his dissent in Agbor, joined by only one other justice, that it would be virtually impossible to prove a malice claim under these circumstances. I'm not suggesting that it's impossible. I'm suggesting it wasn't done in this case, and that's all that we really need to do. There is no evidence of any proceeding by the committee. We do take contest with, and do contest to some extent the CA's reasoning in discussing subjective elements. Because

in essence there is an attempt there to impute knowledge or supposed knowledge by someone who specifically testified that he had no knowledge. And that's Dr. Kerr. It's really the only evidence there is in this record on which they rely apart from their unbased opinion by Dr. Eichhorn. And that is that Dr. Kerr supposedly says that I was told by Dr. Parkinson that someone else had told him that there was a possibility that he was using drugs. Now what is undisputed in this record is, that the Texas Board of Medical Examiners was reviewing these very issues during this credentialing process and had determined to dismiss any of those complaints after their investigation. We do know that, and that is undisputed in this record.

HECHT: If you get as far as the CA got, and I realize you don't think...

MCMAINS: We do think they went too far in bending over to make it look like a harder case than it was.

HECHT: But if you get as far as conscious indifference the way the CA does it, assuming that you can get that far, then isn't the only thing that the CA's found missing at that point was some evidence that the hospital should have done one of the other things that it could have done?

MCMAINS: Well of course the question should invoke elements of negligence, which is one of the big, real difficulties here. Basically I view this notion that in the terms of the manner that it is submitted kind of like a mandamus case. And that is if there is a discretion of the TC to do 2 or 3 things, then you don't get a mandamus because he must be required by law to do one thing. In this case there was only the submission of the initial hiring, and the retention. Which means that basically that he hadn't been fired. That they had to show that that was the only available option that his privileges be summarily suspended prior to this surgery. None of their evidence is very much time related either for that matter. It was very nebulous.

OWEN: I'm having trouble with the timing here. Is it correct that Dr. Kerr was told by someone that they suspected the doctor of drug abuse in 1994?

MCMAINS: Yes. That was Dr. Parkinson, and Dr. Parkinson then took that report and after a conversation with Dr. Kerr, then reported that to the Texas Board of Medical Examiners, who conducted their own review process, which was finalized and found to be no basis for it prior to this surgery.

OWEN: This was in 1994?

MCMAINS: This was in 1994, I believe, when Dr. Parkinson reported this to Dr. Kerr.

OWEN: When was the medical board - when did they close...

MCMAINS: That happened in 1996. And it was after that I believe that he was afforded

the full privileges.

OWEN: On page 15 of petitioner's reply brief on the merits, they have some bullet points that if the hospital had investigated and they go through a number of these. For example, that the office manager testified that she had seen Dr. Baker take hundreds of Vicodin. What was the time frame of these bullet points that they list?

MCMAINS: I believe that it was their report to Dr. Parkinson, who is not a member of the Kingwood Hospital. It was her report to Dr. Parkinson that we're talking about. It was after the initial hiring and before the giving of regular credentials.

OWEN: When did Dr. Baker admit that he had a serious problem and had gone through treatment that was not successful? When did all that occur?

MCMAINS: The admission and what is basically after this case had already been prosecuted or was in the process of being prosecuted. There was no evidence that that had ever been admitted to the hospital, or that anybody at the hospital knew. Dr. Kerr specifically testified that he did not have any hard evidence of either incompetence of the doctor, or that he was a drug abuser. Only that he had had hearsay evidence. And if he had any hard evidence, he said he would have taken it to the Board of Medical Examiners and he didn't, and he specifically testified to that.

OWEN: When did Dr. Baker enroll in a drug counseling program that his office manager attended some of his counseling sessions? When did all of that happen?

MCMAINS: That I don't recollect in terms of dates. Again, all of those records were confidential and were not disclosed to the hospital either because they are drug records. There is no indication whatsoever, no evidence any of that information ever came to the hospital. The only attempted evidence of knowledge of Kingwood of any kind of drug association with Dr. Baker is from Dr. Kerr.

OWEN: They say in their reply brief that had you made the investigation, you would have learned and then they list these things.

MCMAINS: And that's a negligence question and that's the problem. In trying to basically say well you should have done this, or they might have don this, or they could have done this, they don't know whether they did or not. They don't know what they found or didn't. They don't know whether or not there were various options that were pursued. They don't know whether there were any limitations involved. They don't know anything about any action of the hospital committee because of the assertion of the peer privilege, for which there can be no inference under the rule.

OWEN: If we get over the inference hurdle for the moment, that your expert said the hospital would have conducted an investigation, it would have looked at...

MCMAINS: If it had known. And that's they hypothetical that they propose.

OWEN: There's apparently is evidence that Dr. Kerr knew and that he was obligated to take that somewhere and that would have triggered an investigation.

MCMAINS: That was done by way of a hypothetical once again. Assume as they were questioning Dr. Michael, that Dr. Kerr knew. Dr. Kerr specifically testified he didn't know. He said he had heard and that if he had any hard evidence, he would have taken it to the Board. It was taking to the board but not by Dr. Kerr, but by a different party from a different hospital, Dr. Parkinson. The board investigated that, and cleared Dr. Baker. The evidence of that clearing and the hospital's knowledge of that clearing is in the record and is undisputed.

WAINWRIGHT: And when was he cleared?

MCMAINS: He was cleared in 1996. Then you couple that with the little leap in faith that is made with regards to the relationship of this alleged dangerous surgeon going around town, operating on people when he is drug addicted is the causation factor. Because the only evidence or suggestion that there is any drug impact on the actual surgical procedure that's being performed by Dr. Baker is a conclusion drawn by Dr. Eichhorn in interpreting deposition testimony that was made of some of the people and the staff who simply said that Dr. Baker did not appear to understand exactly why there was so much bleeding going on.

Everybody who was in the surgery specifically testified that he did not look impaired, he did not act impaired, he did not act confused. He simply did not look like he understood why there was so much blood loss.

HECHT: You don't seem to question medical malpractice. That was negligence on his part.

MCMAINS: We don't represent Dr. Baker.

HECHT: But you don't seem to question that.

MCMAINS: Well we don't question that there is a connection between the blood loss and the damages.

HECHT: Or that there is faulty judgment.

MCMAINS: That Dr. Baker was negligent in some fashion in causing the blood loss?

HECHT: Yes.

MCMAINS: We don't question that as a practical matter because again we're not appealing

on behalf of Dr. Baker. The argument that the call for additional blood had been made to the hospital in plenty of time to avoid any serious injury to the plaintiff, as the alleged basis for their other negligence, would indicate that the doctor had done what he was supposed to be doing and didn't get the blood products. Their whole argument for some independent ground of negligence is based on the notion that he did exactly what he was supposed to be doing when her perceived that there was too much blood loss.

WAINWRIGHT: And then the hospital according to the briefs took 45 minutes to get the blood there when it should have taken maybe 5 minutes to get it there?

MCMAINS: There is some testimony from their people that it should have gotten there within 5 minutes. There is also testimony that within 45 minutes would have been okay from some of the defendant's experts.

WAINWRIGHT: The objective prong on malice apparently was satisfied here, or at least the jury thought so. It's still a question.

MCMAINS: Clearly the jury was charged just like under Moriel and, yes, they did answer the questions.

WAINWRIGHT: Apparently the jury thought that was actual subjective awareness was satisfied, the second prong of the risk.

MCMAINS: We disagree on both counts.

WAINWRIGHT: If those two facts are established, then why do you need more to establish conscious indifference? If for example, I know that something - there is a very extreme risk of something bad happening if I let Joe go in the room and do something. And I know it's an extreme risk, and I know that Joe is at risk if I let him go in the room and do it, whatever it is without stopping it. What more is needed to establish conscious indifference?

MCMAINS: The point is you need to know what it is you did or didn't do. That is, there must be an act or omission. The entire notion of Moriel as it's been incorporated into ch. 41 and as it was adopted by the court in Agbor in regards to its applicability to the malice definition in this type of an action, is that in order to make that link you must have proceeded with conscious indifference. The jury was so charged. There is no evidence as to the timing of the knowledge, and that's why we disagree with the subjective determination in particular that's imputed to the hospital.

Again, the only real connection between the hospital and the alleged knowledge is the presence of Dr. Kerr who was for a period of time the Chief of Staff of the hospital. He was not chief of staff of the hospital when a lot of the indictments that he made in his conclusions about the competence of Dr. Baker were made before the hospital was even formed in 1990.

OWEN: They say that the hospital's expert on the credentialing process, it was reasonable to assume that the hospital had obtained Dr. Baker's drug treatment records before they credentialed him. Is that accurate?

MCMAINS: It's accurate to the extent that - again these are framed in the form of hypotheticals. Assuming that the doctor had answered these questions on the questionnaire and assuming that they had access to this material they assume that they would have done this investigation. All we are saying is that there really isn't any evidence of what the proceedings were, what they entailed either in the initial credentialing, which of course happened 4 years prior to this surgery, which is too remote in time to have any real causative effect anyway. He operated successfully on a substantial number of patients in-between.

OWEN: At some point in the credentialing process, somebody raised a question, did he have a drug addiction problem?

MCMAINS: Not only is there no direct evidence. We don't believe there is even a permissible inference to the effect that they knew he was a drug abuser. Whether or not that there is some evidence to raise some inference that somebody ought to know something does not get you to the point of malice.

OWEN: That's what I am trying to get at. Was there any evidence that your expert - what did your expert say in context? After Dr. Kerr had heard the rumor did you expert say based on that it's reasonable to assume they would have asked for and gotten his drug treatment records?

MCMAINS: What he said was that it was reasonable for him to - because he was aware that Dr. Parkinson had reported it to the Texas Medical Board and it was reasonable for them to await the outcome of the medical board's investigation. And that if he knew something else, if he had hard evidence then he would have been obliged to take it to the board. And Dr. Kerr specifically denied that he ever had any hard evidence, and that he had not taken it either to the board or to any of the credentialing committee. There is no evidence that anybody made or that any of these witnesses ever made any complaints or objections or filed any statements with regards to any committee with the hospital.

O'NEILL: How do we credit the wife's testimony that the hospital knew?

MCMAINS: Because it's an abstract that she admits on cross examination. She never told them anything. She just said the hospital knew. That was just a conclusion on her part. This is an ex-wife incidentally. And there were various reasons for them to be at odds with one another. That was indicated in the evidence.

That testimony is nothing but just a naked statement of well they knew. And without any basis whatsoever or foundation for any argument that they did in fact know. Now particularly in light of the fact that this is a clear and convincing case. And in my judgment that the

standard of appellate review is heightened as a result of that. It's even more egregious to suggest that this is sufficient evidence to support the legally sufficiency of the malicious credentialing.

JEFFERSON: When the standard is clear and convincing should the court - you know when someone is attempting to prove the matter by inference, should the court require the plaintiff to disprove some of the defendant's...

MCMAINS: I don't believe that was necessarily the effect of what the CA was holding. I think really what they were saying is, that if you can have multiple different conclusions as a result of the same piece of evidence that particularly in a clear and convincing case that's not enough to get you on down the road.

JEFFERSON: Let's say there is some evidence that the inference would support liability is more likely than not. Some evidence that will get you to that hurdle. But does it get you to - what do you need more to get you to the clear and convincing theory, clear and convincing evidence? And if it takes more does that mean that the plaintiff has a heightened burden at trial before the trier of fact?

MCMAINS: I do think that the plaintiff has a heightened burden at trial with a clear and convincing standard.

JEFFERSON: To disprove the theory?

MCMAINS: Not so much in terms of disproving things, but in terms of merely measuring the strength of the evidence, the strength of the inference necessary to rise to the level of being some evidence in light of the clear and convincing standard that produced a definite and firm conviction. And for instance the testimony of the wife in the abstract, the hospital knew would in my judgment never rise to that level. I don't think it rises even to the level under a regular legal sufficiency review. Let alone under the heightened legal sufficiency review that I think is applicable in a clear and convincing case.

O'NEILL: If there were evidence from which an inference could be made that the hospital did know about the drug problem, could you get malice just simply from the fact they didn't suspend privileges?

MCMAINS: I don't believe so. For the reasons that I indicated. Even their own expert said that there were various alternatives that could be taken, short of suspension.

O'NEILL: It's undisputed they weren't taken. Correct?

MCMAINS: No. It's not undisputed that none of these things were taken. It's undisputed that there is none proved in the record. There's none proved as to what the status of any investigation or complaints were made because of the fact that the assertion _____.

O'NEILL: There is no such thing as a malicious credentialing. Right?

MCMAINS: Yes.

O'NEILL: I don't know how you could ever prove it if you can't find out this information and draw certain inferences from it.

MCMAINS: For instance, the nurse that testified that worked for the doctor outside the hospital takes the position if she had made complaints there would be evidence that there were complaints made. If there were numerous evidence of complaints independently that were made, that would at least indicate that there was knowledge or suspicion that generally could be imputed to the hospital. But that was not the case in this record.

O'NEILL: Presuming there was evidence that would support an inference that the hospital knew, your position is, it's still not enough from a malicious credentialing that they didn't suspend his privileges?

MCMAINS: That being the only alternative that they had under these circumstances, you had no choice but to fire this individual or permanently suspending, terminating whatever. That's your only alternative. I believe that that's not - that there's not a sufficient basis to do that. Since that's the only issue that was really before the court.

O'NEILL: So you're just saying we can't infer that they didn't take alternative measures, but we can never know?

MCMAINS: Not so long as the privilege is recognized, both by the statutes and by this court.

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REBUTTAL

HECHT: With regards to the standard of review on appeal, and it's argued in the response and then in your reply, whether it should be elevated in a case in which the burden and the proof at trial is clear and convincing evidence. I take it your position is that if it is elevated you still succeed?

HOGAN: Yes. The court's questions to me and of course what the CA wrote in its opinion suggests that what needed to have happened in this case and the way to alleviate the harm is to submit an apportionment question that doesn't include malice. That took the jury's finding of the negligence and the first separately submitted issue, and gave an apportionment question and said, now among those people who you have decided were negligent apportion responsibility, and don't consider the hospital's credentialing activities in answering this apportionment question.

The problem is, is that's the exactly what the hospital rejected. The TC specifically offered that question to the hospital. It's on the record. She said, that will cure your harm and your Casteel complaint that we're not going to be able to tell what the jury is doing with this apportionment question. And the hospital said, we don't want that question. I think that it's impossible to really come to terms with this case or the way a charge ought to be submitted. We can debate in the abstract whether it's a good idea to have multiple apportionment questions. And I think it becomes so granulated and the charge becomes so _____ really that it makes no sense for us to go from a policy standpoint that direction.

But assuming that there's a case in which it's feasible and practical, then surely the parties need to tell the TC that. And they ought to tell the other side that too, because the whole purpose of charge objections, and error preservation is so that we can get it right in the TC, so that we don't wind up here having to have the entirety of a case remanded. This could have been fixed in the TC. If the harm is that the damages question had a single predication on the two issues, then all that needed to happen was an objection needed to be lodged to that and a suggestion that they be separated. That did not happen.

WAINWRIGHT: At page 11 of the respondent's brief, they quote part of the trial record here. And it's the hospital speaking. In question no. 3, the apportionment question, we object to the identification...along with a negligence theory resulting in a single percentage inquiry which could...make it impossible to determine that there was a legally legitimate basis upon which rendition of judgment could be had." Why is that not an objection to a single portion of the question?

HOGAN: What follows that statement is the court. I would be glad to cure that for you.

Mr Sheehee: Your honor we discussed this yesterday and I think at the times I didn't want to sandbag the court.

The court: Now I understand you're making the objection but you know it is my belief that there ought to be two predicate questions. Two causation questions?

The court: Mr. Sheehay. Two percentage questions?

The court: Two percentage questions and that would cure the problem.

Mr. Sheehay: I understand the court's position.

The court: Okay.

That's why, because we don't look...

WAINWRIGHT: So the answer is to read the rest of the record?

HOGAN: Yes. They were offered it specifically and they rejected it. And this court has said, we don't look at just one narrow, little point in time, and one little sentence that someone says in deciding whether error is preserved. We can go back in time and look to see whether someone apprised the court. We can go forward in time to see whether someone apprised the court. But you've got to read the entirety of this discussion to see that these guys were rejecting the very thing that would have corrected the problem.